

STATE OF OHIO )  
 ) SS.  
COUNTY OF \_\_\_\_\_ )

## **AFFIDAVIT**

I, \_\_\_\_\_, being first duly sworn, depose and say for the  
(Name of Group Official)  
purposes of obtaining insurance coverage with Medical Mutual of Ohio™ (“MMO”) through its contract with Group Services, Inc. that:

1. I am the \_\_\_\_\_ for \_\_\_\_\_ (“Group”).  
(Title) (Name of Group)  
I am an authorized representative of Group and have full power and authority to act on behalf of Group and legally bind it.
2. The Group is a for-profit organization duly organized and licensed to conduct business in the State of Ohio.
3. The Group was not organized or created for the purpose of obtaining insurance.
4. All Group members who apply for insurance coverage from MMO are full-time employees of the Group, drawing regular paychecks, and compensation is reported by the Group to the IRS on W-2 forms.
5. The Group is providing Workers’ Compensation coverage for all Group members who apply for MMO insurance coverage.
6. To be considered full-time employees, Group members must work the following minimum number of hours per week: \_\_\_\_\_.
7. I understand and acknowledge that I am familiar with the Underwriting Regulations for Group Services, Inc. group members and that any insurance coverage for my Group is subject to compliance with said Regulations.
8. I understand and acknowledge that MMO has the right to void insurance coverage for the Group and/or any Group member, as applicable, should any of the above information be found to be false, and MMO may also void coverage for the Group and/or Group members, as applicable, should the Group and/or Group members engage in fraudulent conduct, deception or misrepresentation relating to any application, coverage, any claim or any usage of an MMO identification card.

I certify that I understand the contents of this Affidavit and further certify that the information stated above is true and accurate, that it may be relied upon by MMO, and that I will promptly notify MMO of any changes in the eligibility of persons enrolled through this Group.

9. All of the employees for \_\_\_\_\_ are listed below.  
(Name of Group)

NAME	SOCIAL SECURITY NUMBER	HIRE DATE	NUMBER OF HOURS WORKED PER WEEK	NUMBER OF WEEKS PER YEAR

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

SWORN TO BEFORE ME and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, 199\_\_\_\_.